Lymphogranuloma Venereum (LGV) Suspected Case-Patient Information

If you have a suspected LGV case or questions about this form, please contact Dr. Catherine McLean at the Centers for Disease Control and Prevention's Division of STD Prevention at (404) 639-8467, Fax # (404) 639-8610 or CMcLean@cdc.gov.

Today's Date : M M - D D - Y Y

Name of Person Completing this Form:_____

Affiliation (e.g. clinic, health department) :_____

Phone # :_____ Fax # :_____ Email :_____

Clinic Where Patient was Seen for Suspected LGV :_____

Clinic Location : City_____ State :_____

Clinic Type: ☐ STD Clinic ☐ Primary Care
☐ HIV/AIDS/ID Clinic ☐ Emergency Department
☐ Other (Specify Type):_____

Patient's Clinic ID#:_____

Was your local or state health department informed of this suspected case? ☐ yes ☐ no ☐ unk
If no or unknown, please contact your local health department.

Patient's Demographic Information

1. Sex: ☐ Male ☐ Female ☐ Transgender (☐ M-to-F or ☐ F-to-M)

2. Age:_____ 3. State Where Patient Resides: _____ 4. Patient's Zipcode: __ __ __ __ __

5. Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

6. Race (Check all that apply): ☐ American Indian/Alaskan Native ☐ White
☐ Native Hawaiian/Pacific Islander ☐ Black
☐ Asian ☐ Other:_____
☐ Don't know

Clinical Information

7. Date of Initial Health Care Visit for Suspected LGV: M M - D D - Y Y

8. What was the patient's chief complaint(s) at the initial clinic visit for suspected LGV ?
_____

9. Is this patient the sex partner of a person diagnosed with proven or suspected LGV ?
☐ yes ☐ no ☐ unknown

10. Does the patient report having a sex partner with symptoms consistent with LGV?
☐ yes ☐ no ☐ unknown

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11. **Symptoms:** Did the patient report having any of the following symptoms?

Symptom		Duration (# Days)	Still Present?
Anal Discharge	□ yes □ no □ unk		□ yes □ no □ unk
Rectal Bleeding	□ yes □ no □ unk		□ yes □ no □ unk
Constipation	□ yes □ no □ unk		□ yes □ no □ unk
Lymph node enlargement in groin	□ yes □ no □ unk		□ yes □ no □ unk
Ulcer Painful? □ yes □ no Site:_____	□ yes □ no □ unk		□ yes □ no □ unk
Papule Painful? □ yes □ no Site:_____	□ yes □ no □ unk		□ yes □ no □ unk
Fever	□ yes □ no □ unk		□ yes □ no □ unk
Weight Loss	□ yes □ no □ unk		□ yes □ no □ unk
Anal Spasms (cramping)	□ yes □ no □ unk		□ yes □ no □ unk
Other:_____	□ yes □ no □ unk		□ yes □ no □ unk

12. **Clinical Exam Findings** (*Check all that apply) :*

□ Inguinal Lymphadenopathy (Bubo) □ unilateral □ bilateral □ tender at adenopathy site	□ Mucous or purulent anal discharge	Rectal exam (digital), findings (if done): _____ _____ _____
□ Ulcer Tender? □ yes □ no Site:_____	□ Rectal bleeding	Anoscopy/Proctoscopy Done ? □ yes □ no □ unk Findings/Visualization :_____ _____ _____
□ Papule Tender ? □ yes □ no Site:_____	□ Fever	
□ Other (List) :_____	□ Weight loss	Sigmoidoscopy Done? □ yes □ no □ unk Findings/Visualization :_____ _____ _____

13. Was treatment given for suspected LGV ? □ yes □ no □ unknown
Drug:_____ Dose:_____ Frequency:_____ #Days:_____

14. Does the patient have a history of chlamydial infection in the past year (not including current diagnosis)? □ yes □ no □ don't know
14a. If yes, #1 Anatomic Site:_____ Date: M M - D D - Y Y Tx:_____
#2 Anatomic Site:_____ Date: M M - D D - Y Y Tx:_____

15. Patient's HIV Status : □ positive □ negative □ unknown Last Test, if known: M M - D D - Y Y

15a. If HIV+, Most recent CD4 Count:_____ Date: M M - D D - Y Y
Most recent Viral Load: _____ Date: M M - D D - Y Y

16. Check other STDs for which tests were conducted at the initial LGV clinic visit and test results, if available *(Check all that apply)*.

STD	Test Results	Test Type
☐ **Gonorrhea--Urine**	☐ positive ☐ negative ☐ unk	☐ NAATS ☐ unk
☐ **Gonorrhea--Rectal**	☐ positive ☐ negative ☐ unk	☐ culture ☐ unk ☐ NAATS
☐ **Gonorrhea--Oropharyngeal**	☐ positive ☐ negative ☐ unk	☐ culture ☐ unk ☐ NAATS
☐ **Trichomonas**	☐ positive ☐ negative ☐ unk	☐ culture ☐ unk ☐ wet mount
☐ **Syphilis—Non-Treponemal Test**	☐ reactive ☐ non-reactive ☐ unk Titer: _____/_____	☐ RPR ☐ VDRL ☐ Other_____ ☐ unk
☐ **Syphilis—Treponemal Test**	☐ reactive ☐ non-reactive ☐ unk	☐ FTA-ABS ☐ TP-PA ☐ Other_____ ☐ unk
☐ **Syphilis Ulcer/Chancre**	☐ positive ☐ negative ☐ unk	☐ Darkfield ☐ unk
☐ **Genital/Rectal Herpes**	☐ positive ☐ negative ☐ unk	☐ culture ☐ unk ☐ other_____
☐ **Other**		

17. Chlamydia Diagnostic Tests at Visit for Suspected LGV :

CT Specimen Type/Lab Used	CT Test Results	Test Type (if known)
☐ **Urine** **Lab Name:** _____	☐ positive ☐ equivocal ☐ negative ☐ unknown	☐ GenProbe Aptima ☐ Roche Amplicor ☐ BD ProbeTec ☐ Other:_____
☐ **Urethral Swab** **Lab Name:** _____	☐ positive ☐ equivocal ☐ negative ☐ unknown	☐ Culture ☐ GenProbe Aptima ☐ GenProbe PACE ☐ BD ProbeTec ☐ Roche Amplicor ☐ unknown ☐ Antigen detection(specify):_____ ☐ Other(specify):_____
☐ **Rectal Swab #1** **Lab Name:** _____	☐ positive ☐ equivocal ☐ negative ☐ unknown	☐ Culture ☐ GenProbe Aptima ☐ GenProbe PACE ☐ BD ProbeTec ☐ Roche Amplicor ☐ unknown ☐ Other (specify): _____ **Was specimen collected under direct visualization during anoscopy or sigmoidoscopy ?** ☐ yes ☐ no ☐ unknown
☐ **Rectal Swab #2** **Lab Name:** _____	☐ positive ☐ equivocal ☐ negative ☐ unknown	☐ Culture ☐ GenProbe Aptima ☐ GenProbe PACE ☐ BD ProbeTec ☐ Roche Amplicor ☐ unknown ☐ Other (specify): _____ **Was specimen collected under direct visualization during anoscopy or sigmoidoscopy ?** ☐ yes ☐ no ☐ unknown
☐ **Serology** **Lab Name:** _____	Titer (if known):____/____ Optical Density (if done):_____	☐ CF ☐ MIF ☐ EIA ☐ Other
☐ **Other:_____** **Lab Name:_____**	Describe Results :	Describe Test Type:

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Patient's Sexual and Travel History (if available)

18. Did patient exchange sex for drugs or money in the past 60 days?
□ yes □ no □ unknown

19. Number of **male sex partners** the patient had in the past 60 days :_____

19a. Did the patient have sex (anal, vaginal) without a condom with any of these male partners? □ yes □ no □ unknown

19b. Did the patient have receptive anal intercourse with any of these male partners?
□ yes □ no □ unknown

19c. For male patients only: Did the patient have insertive anal intercourse with any of these male partners? □ yes □ no □ unknown

20. Number of **female sex partners** the patient had in the past 60 days :_____

For male patients only:

20a. Did the patient have insertive anal intercourse with any of these female partners?
□ yes □ no □ unknown

21. Did the patient travel outside the state where the clinic is located in the past 60 days (including international travel)? □ yes □ no □ unknown

21a. If yes, where did the patient travel (include dates)?

Location : _____ Dates :_____
Location : _____ Dates : _____
Location :_____ Dates :_____

21b. Did the patient have sex with a person from that area or another traveler while there?
□ yes □ no □ unknown

If yes, which location and indicate if sex was with someone from the local area or a fellow traveler for each:

Location : _____ and contact:_____
Location : _____ and contact: _____
Location :_____ and contact:_____

Additional Comments You Have (e.g. other history, risk factors, or behaviors of relevance for this suspected case:

Thank you for your time. Please fax this form to Dr. Catherine McLean at (404) 639-8610